EM PACKET

Listed below are forms that require either a signature and/or other documentation that has been specified:

Request for Temporary Emergency Appointment

Acknowledgement of Emergency Employment Status

Maryland New Hire Registry Reporting Form

Authority to Release of Information

I-9 Form U.S. Department of Justice Employment Eligibility Verification **(attached copy of acceptable documents as required and listed on back of form)**

W-4 Form Withholding Allowance Certificate

Emergency Form

Health Statement of Ability for Sedentary and Light Duty Work

Employee Disclosure of Criminal History

Combined IRMA Policy Acknowledgement Form

DHMH Policies Acknowledgements

Should you have any questions or need assistance, please feel free to contact your Personnel Officer on 410-767-6403.

REQUEST FOR TEMPORARY EMERGENCY APPOINTMENT

UNIT'S NAME: _____

APPROPRIATION CODE: 32._____._____._____._____ _____
PROGRAM SUB-PROG FUND

REQUESTED CLASSIFICATION AND CLASSIFICATION CODE: _____

CLASSIFICATION GRADE AND REQUESTED STEP: _____
(If request is for a salary above base, complete attached Form)

FUNCTION TO BE PERFORMED BY POSITION: _____
_____
_____
_____

REASON WHY AN EXISTING PERMANENT POSITION COULD NOT BE USED TO PERFORM THIS FUNCTION: _____
_____
_____

REASON/JUSTIFICATION FOR REQUEST TO HIRE VIA TEMPORARY EMERGENCY EMPLOYMENT: _
_____
_____

SELECTED APPLICANTS NAME: _____ SS# _____

STARTING DATE (Must Have Prior Approval): _____

ENDING DATE (May Not Exceed 6 Months): _____

FULL TIME _____ PART TIME _____ % OF EMPLOYMENT _____

_____ _____
APPOINTING AUTHORITY/DESIGNEE SIGNATURE DATE

_____ _____
PRINT NAME PHONE NUMBER

_____ _____
FISCAL OFFICER'S SIGNATURE DATE
Certification of the availability of source of funding for this reason

_____
PRINT NAME

_____ _____
PERSONNEL OFFICER'S SIGNATURE DATE

_____ _____
PRINT NAME PHONE NUMBER

Attachment – State Application completed to include birthdate, race and sex.

REVISED 3/06

APPLICANT SALARY REQUEST LETTER

NAME: _____

SS#: _____

DATE: _____

POSITION: _____

Complete One (Verification Required):

Current Salary _____/Hour

Previous Salary _____/Hour

Competing Job Offer Amount _____/Hour

The lowest salary I will accept if offered this position _____.

Base _____/hour

Step 1 _____/hour Step 2 _____/hour

Step 3 _____/hour Step 4 _____/hour

Step 5 _____/hour Step 6 _____/hour

Step 7 _____/hour Step 8 _____/hour

_____

Applicant's Signature & Date

Revised 12/09

ACKNOWLEDGEMENT OF EMERGENCY EMPLOYMENT STATUS

You have accepted an emergency appointment with the State of Maryland . Under Title 17, Subtitle 04, the following conditions apply to an employee in a emergency status:

EM Appointment

This kind of appointment is subject to the following conditions:

A. You are entitled to be paid for hours worked based on the salary for the classification in which you are hired.

B. You will receive overtime payment and shift differential, where permitted.

C. You will not be entitled to the usual employee benefits such as paid holidays, leave, retirement, health insurance and salary increments.

D. Your EM appointment cannot exceed six months.

E. This appointment will not operate to place you in a favored position for any future hiring purposes. Consideration will be given to the experience you acquired during this emergency appointment in considering your qualifications.

I, the undersigned, certify that I have reviewed the aforegoing "Acknowledgement OF Emergency Employment Status". Its contents have been explained to me by a member of the hiring agency's personnel unit and I understand the terms of my emergency employment with the (department) _____ effective _____

_____ _____

Date Signature

Maryland New Hire Registry Reporting Form

Send completed forms to:
Maryland New Hire Registry
PO Box 1316
Baltimore, MD 21203-1316
Fax: (410) 281-6004 or toll-free fax 1 (888) 657-3534

To ensure the highest level of accuracy, please print neatly in capital letters and avoid contact with the edges of the boxes. The following will serve as an example:

A	B	C

1	2	3

EMPLOYER INFORMATION

Federal Employer Id Number (FEIN):

Please use the same FEIN that appears on quarterly wage reports.

State Unemployment Insurance Number (MD Only SUIN):

If SUIN not issued yet, please write "APPLIEDFOR" in the above box. If Exempt, write "EXEMPT".

Employer Name:

Employer Address *(Please indicate the address where the Income Withholding Orders should be sent)*:

Employer City:

Employer State: Zip Code (5 digit):

Employer Phone (optional):

Employer Fax (optional):

Contact Name (optional):

Email (optional):

EMPLOYEE INFORMATION

Employee Social Security Number (SSN):

Date of Hire (mm/dd/yyyy):

Employee First Name:

Middle Initial (optional):

Employee Last Name:

Employee Address:

Employee City:

Employee State:

Zip Code (5 digit):

Date of Birth mm/dd/yyyy (optional):

Employee Salary (Dollars and Cents):

Hourly

Monthly

Yearly

Are health care benefits available to employee? (Y/N):

Employee Gender (M)ale/(F)emale:

Reports must be submitted within 20 days of the date of hire or rehire

Rev (09/02)

uestions? Call us at (410) 281-6000 or toll-free 1 (888) MDHIRES (634-4737). Report online at www.mdnewhire.com

STATE OF MARYLAND
DHMH

Maryland Department of Health and Mental Hygiene
201 W. Preston Street • Baltimore, Maryland 21201
Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – John M. Colmers, Secretary

OFFICE OF HUMAN RESOURCES

AUTHORITY FOR RELEASE OF INFORMATION

As an applicant for a position with the Maryland Department of Health and Mental Hygiene, I have been asked to furnish information for use in reviewing my background and qualifications. In this connection, I hereby authorize the Department to investigate my past work history, character, education, military and police records to ascertain any and all information which may be pertinent to my employment qualifications.

I direct you to release such information upon request of the duly accredited representative of the Maryland Department of Health and Mental Hygiene regardless of any agreement I may have made with you previously to the contrary and regardless of any other legal obligation that you may be subject to regarding the release of such information.

I understand that the information you release is for official use by the Maryland Department of Health and Mental Hygiene, and that the Maryland Department of Health and Mental Hygiene may disclose the information you release as authorized by law.

I release any individual, including records custodians, from all liability for damages that may result to me on account of compliance or any attempts to comply with this authorization. This release is binding, now and in the future, on my heirs, assigns, associates, and personal representative(s) of any nature. Copies of this authorization that show my signature are as valid as the original release signed by me.

NAME: _____

PRINTED **DATE**

_____

SIGNATURE

_____

WITNESS **DATE**

NOTE: Consequences for failing to grant this release or for fraudulent or irregular information may include, but are not limited to, non-selection, decertification, termination of employment in situations where employment has begun, notification to the Secretary, and criminal prosecution.

Rev. 2/07

2010 EMPLOYEE WITHHOLDING ALLOWANCE CERTIFICATE
FOR MARYLAND STATE GOVERNMENT EMPLOYEES ONLY

Form W-4
Department of the Treasury
Internal Revenue Service

Form MW 507
Comptroller of Maryland

Please complete form in black ink. Whether you are entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.

Section 1 - Employee Information

Payroll System *(check one)* RG ☐ CT ☐ UM ☐	Name of Employing Agency		
Agency Number	Social Security Number	Employee Name	
Home Address (number and street or rural route)		Address Continued (apartment number, if any)	
City	State	Zip Code	County of Residence (required)

Section 2 - Federal Withholding Form W-4

The federal worksheet is available online at http://www.irs.gov/pub/irs-pdf/fw4.pdf

3 Single ☐ Married ☐ Married, but withhold at higher Single Rate ☐ Note. If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.	4 If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a new card. ➤ ☐	
5 Total number of allowances you are claiming (from page 1 or page 2 of the federal worksheet)	5	
6 Additional amount, if any, you want withheld from each paycheck	6	$
7 I claim exemption from withholding for 2010, and I certify that I meet **both** of the following conditions for exemption. • Last year I had a right to a refund of all federal income tax withheld because I had no tax liability and • This year I expect a refund of all federal income tax withheld because I expect to have no tax liability If you meet both conditions, write "Exempt" here ➤	7	

Section 3 - Maryland Withholding Form MW 507

The Maryland worksheet is available online at http://forms.marylandtaxes.com/current_forms/MW507.pdf

Withhold at Single Rate ☐ Married (surviving spouse or unmarried Head of Household) Rate ☐ Married, but withhold at Single Rate ☐

1. Total number of exemptions you are claiming from Maryland worksheet 1. _____
2. Additional withholding per pay period under agreement with employer 2. _____
3. I claim exemption from withholding because I do not expect to owe Maryland tax. See instructions below and check boxes that apply.

   ☐ a. Last year I did not owe any Maryland income tax and had a right to a full refund of all income tax withheld.
   AND
   ☐ b. This year I do not expect to owe any Maryland income tax and expect to have the right to a full refund of all income tax withheld. (This includes seasonal and student employees whose annual income will be below the minimum filing requirement).

   If both a and b apply, enter year applicable _____ (year effective) Enter "EXEMPT" here 3._____
4. I claim exemption from withholding because I am domiciled in one of the folowing states. Check state that applies.

   ☐ Pennsylvania (indicate township/borough under Address Continued in section 1 above.) ☐ Virginia

   I further certify that I do not maintain a place of abode in Maryland as described in the instructions on page 2 of the worksheet
   Enter "EXEMPT" here 4. _____
5. I certify that I am a legal resident of the state of_____ and am not subject to Maryland withholding because I meet the requirements set forth under the Servicemembers Civil Relief Act, as amended by the Military Spouses Residency Relief Act.
   Enter "EXEMPT" here 5._____

Section 4 - Employee Signature

Under penalties of perjury, I declare that I have examined this certificate and to the best of my knowledge and belief, it is true, correct, and complete. I further certify that I am entitled to the number of withholding allowances claimed on line 1 above, or if claiming exemption from withholding, that I am entitled to claim the exempt status on line 3, 4 or 5, whichever applies.

Employee's signature
(Form is not valid unless you sign it.) _____ Date_____

Employer's name and address (including zip code) - For employer use only Central Payroll Bureau P.O. Box 2396 Annapolis, MD 21404	Federal Employer identification number 52-6002033 (For State of Maryland - CPB use only)

Important: The information you supply must be complete. This form will replace in total any certificate you previously submitted.
Web Site - http://compnet.comp.state.md.us/cpb

OMB No. 1615-0047; Expires 08/31/12

Department of Homeland Security
U.S. Citizenship and Immigration Services

Form I-9, Employment Eligibility Verification

Read instructions carefully before completing this form. The instructions must be available during completion of this form.

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers CANNOT specify which document(s) they will accept from an employee. The refusal to hire an individual because the documents have a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Verification *(To be completed and signed by employee at the time employment begins.)*

Print Name: Last	First	Middle Initial	Maiden Name
Address *(Street Name and Number)*		Apt. #	Date of Birth *(month/day/year)*
City	State	Zip Code	Social Security #

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following):

- ☐ A citizen of the United States
- ☐ A noncitizen national of the United States (see instructions)
- ☐ A lawful permanent resident (Alien #) _____
- ☐ An alien authorized to work (Alien # or Admission #) _____ until (expiration date, if applicable - *month/day/year*) _____

Employee's Signature — Date *(month/day/year)*

Preparer and/or Translator Certification *(To be completed and signed if Section 1 is prepared by a person other than the employee.) I attest, under penalty of perjury, that I have assisted in the completion of this form and that to the best of my knowledge the information is true and correct.*

Preparer's/Translator's Signature	Print Name
Address *(Street Name and Number, City, State, Zip Code)*	Date *(month/day/year)*

Section 2. Employer Review and Verification *(To be completed and signed by employer. Examine one document from List A OR examine one document from List B and one from List C, as listed on the reverse of this form, and record the title, number, and expiration date, if any, of the document(s).)*

List A	OR	List B	AND	List C
Document title:				
Issuing authority:				
Document #:				
Expiration Date *(if any)*:				
Document #:				
Expiration Date *(if any)*:				

CERTIFICATION: I attest, under penalty of perjury, that I have examined the document(s) presented by the above-named employee, that the above-listed document(s) appear to be genuine and to relate to the employee named, that the employee began employment on *(month/day/year)* _____ **and that to the best of my knowledge the employee is authorized to work in the United States. (State employment agencies may omit the date the employee began employment.)**

Signature of Employer or Authorized Representative	Print Name	Title
Business or Organization Name and Address *(Street Name and Number, City, State, Zip Code)*		Date *(month/day/year)*

Section 3. Updating and Reverification *(To be completed and signed by employer.)*

A. New Name *(if applicable)*	B. Date of Rehire *(month/day/year) (if applicable)*

C. If employee's previous grant of work authorization has expired, provide the information below for the document that establishes current employment authorization.

Document Title: _____ Document #: _____ Expiration Date *(if any)*: _____

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

Signature of Employer or Authorized Representative	Date *(month/day/year)*

OMB No. 1615-0047; Expires 08/31/12

Department of Homeland Security
U.S. Citizenship and Immigration Services

Form I-9, Employment Eligibility Verification

Instructions

Read all instructions carefully before completing this form.

Anti-Discrimination Notice. It is illegal to discriminate against any individual (other than an alien not authorized to work in the United States) in hiring, discharging, or recruiting or referring for a fee because of that individual's national origin or citizenship status. It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) they will accept from an employee. The refusal to hire an individual because the documents presented have a future expiration date may also constitute illegal discrimination. For more information, call the Office of Special Counsel for Immigration Related Unfair Employment Practices at 1-800-255-8155.

What Is the Purpose of This Form?

The purpose of this form is to document that each new employee (both citizen and noncitizen) hired after November 6, 1986, is authorized to work in the United States.

When Should Form I-9 Be Used?

All employees (citizens and noncitizens) hired after November 6, 1986, and working in the United States must complete Form I-9.

Filling Out Form I-9

Section 1, Employee

This part of the form must be completed no later than the time of hire, which is the actual beginning of employment. Providing the Social Security Number is voluntary, except for employees hired by employers participating in the USCIS Electronic Employment Eligibility Verification Program (E-Verify). **The employer is responsible for ensuring that Section 1 is timely and properly completed.**

Noncitizen nationals of the United States are persons born in American Samoa, certain former citizens of the former Trust Territory of the Pacific Islands, and certain children of noncitizen nationals born abroad.

Employers should note the work authorization expiration date (if any) shown in **Section 1**. For employees who indicate an employment authorization expiration date in **Section 1**, employers are required to reverify employment authorization for employment on or before the date shown. Note that some employees may leave the expiration date blank if they are aliens whose work authorization does not expire (e.g., asylees, refugees, certain citizens of the Federated States of Micronesia or the Republic of the Marshall Islands). For such employees, reverification does not apply unless they choose to present in Section 2 evidence of employment authorization that contains an expiration date (e.g., Employment Authorization Document (Form I-766)).

Preparer/Translator Certification

The Preparer/Translator Certification must be completed if **Section 1** is prepared by a person other than the employee. A preparer/translator may be used only when the employee is unable to complete **Section 1** on his or her own. However, the employee must still sign **Section 1** personally.

Section 2, Employer

For the purpose of completing this form, the term "employer" means all employers including those recruiters and referrers for a fee who are agricultural associations, agricultural employers, or farm labor contractors. Employers must complete **Section 2** by examining evidence of identity and employment authorization within three business days of the date employment begins. However, if an employer hires an individual for less than three business days, **Section 2** must be completed at the time employment begins. Employers cannot specify which document(s) listed on the last page of Form I-9 employees present to establish identity and employment authorization. Employees may present any List A document **OR** a combination of a List B and a List C document.

If an employee is unable to present a required document (or documents), the employee must present an acceptable receipt in lieu of a document listed on the last page of this form. Receipts showing that a person has applied for an initial grant of employment authorization, or for renewal of employment authorization, are not acceptable. Employees must present receipts within three business days of the date employment begins and must present valid replacement documents within 90 days or other specified time.

Employers must record in Section 2:

1. Document title;
2. Issuing authority;
3. Document number;
4. Expiration date, if any; and
5. The date employment begins.

Employers must sign and date the certification in **Section 2**. Employees must present original documents. Employers may, but are not required to, photocopy the document(s) presented. If photocopies are made, they must be made for all new hires. Photocopies may only be used for the verification process and must be retained with Form I-9. **Employers are still responsible for completing and retaining Form I-9.**

Paperwork Reduction Act

An agency may not conduct or sponsor an information collection and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. The public reporting burden for this collection of information is estimated at 12 minutes per response, including the time for reviewing instructions and completing and submitting the form. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: U.S. Citizenship and Immigration Services, Regulatory Management Division, 111 Massachusetts Avenue, N.W., 3rd Floor, Suite 3008, Washington, DC 20529-2210. OMB No. 1615-0047. **Do not mail your completed Form I-9 to this address.**

DEPARTMENT OF HEALTH & MENTAL HYGIENE

EMERGENCY FORM

SOCIAL SECURITY NUMBER: _____

NAME: _____
Last First Middle

SEX: _____ TELEPHONE NUMBER: _____

ASSIGNMENT WITHIN DHMH: _____
Program Division

IN CASE OF EMERGENCY NOTIFY: _____

RELATIONSHIP: _____

ADDRESS: _____
No. & Street City State Zip

TELEPHONE NUMBER: _____

DHMH 1491

MARYLAND STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE

HEALTH STATEMENT OF ABILITY FOR SEDENTARY AND LIGHT-DUTY WORK

I have read and/or have had explained to me the responsibilities, functions and work environment of a _____ , the job which has been offered to me, and attest that, to the best of my knowledge, I am physically and mentally capable of the safe and effective performance of all job-related functions of this classification.

_____
Signature of Employee

_____
Date

In principle, State employees should be responsible for and required to have and maintain a state of health and fitness that allows them to carry out their required job-related tasks without detriment to the effectiveness of their employing agency or themselves.

DHMH 1470
Revised 11/01

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
OFFICE OF HUMAN RESOURCES

EMPLOYEE DISCLOSURE OF CRIMINAL HISTORY

A record of criminal conviction is not an automatic bar to employment. Each case is considered on its own merits. Factors such as job-relatedness, age at the time of conviction, nature of the offense, success of rehabilitation, number of convictions, and recentness of the conviction(s) are taken into consideration to determine whether a criminal record disqualifies a candidate for employment.

Background and criminal record checks to include fingerprinting are routinely completed for all appointments.

Discovery of fraudulent, irregular or inaccurate information will be reported to appropriate State agencies.

Falsification of this form, or any other employment application form, will result in automatic rejection of the employment application, withdrawal of commitment, or immediate dismissal from employment.

HAVE YOU EVER BEEN **CONVICTED**, RECEIVED A **PROBATION BEFORE JUDGMENT**, OR RECEIVED A **NOT CRIMINALLY RESPONSIBLE DISPOSITION** OF ANY CRIMINAL CASE OTHER THAN A MINOR TRAFFIC VIOLATION?

_____ YES **(If YES, give complete details on the second page of this form.)**

_____ NO

_____ _____
SIGNATURE (FULL NAME) DATE

_____
PRINT FULL NAME

_____
SUPERVISOR'S SIGNATURE

Form 4503 (4/09)

PLEASE PRINT

1. CRIME CONVICTED OF: _____

   DATE OF INCIDENT: _____

   DATE CONVICTED: _____

   DISPOSITION OF CASE: _____

2. CRIME CONVICTED OF: _____

   DATE OF INCIDENT: _____

   DATE CONVICTED: _____

   DISPOSITION OF CASE: _____

3. CRIME CONVICTED OF: _____

   DATE OF INCIDENT: _____

   DATE CONVICTED: _____

   DISPOSITION OF CASE: _____

4. CRIME CONVICTED OF: _____

   DATE OF INCIDENT: _____

   DATE CONVICTED: _____

   DISPOSITION OF CASE: _____

Applicant's Name: _____ Date: _____
Please Print

Applicant's Signature: _____

COMBINED IRMA POLICY ACKNOWLEDGMENT FORM

This document is a combined policy acknowledgment form for DHMH computer-related policies. Following consultation with your supervisor, please read and initial the appropriate acknowledgment sections, then sign the signature block below.

Acknowledgement Section

Employee Initials	Supervisor Initials °	Policy Number-Statement
		02.01.01 Policy on the Use of DHMH Electronic Information Systems (EIS) I hereby acknowledge awareness of **DHMH Policy 02.01.01**, and that my use of these systems constitutes my consent to comply with this directive.
		02.01.02-Software Copyright Policy & the State of Maryland Software Code Of Ethics- Unauthorized duplication of copyrighted computer software violates the law and is contrary to the State's standards of conduct. The State disapproves of such copying and recognizes the following principles as a basis for preventing its occurrence. **1. The State will not permit the making or using of unauthorized software copies under any circumstances.** **2. The State will provide legally acquired software to meet its legitimate software needs in a timely fashion and in sufficient quantities to satisfy those needs.** **3. The State will enforce internal controls to prevent the making or using of unauthorized software copies, including measures to verify compliance with these standards and appropriate disciplinary actions for violations of these standards.** I understand that making or using unauthorized software will subject me to appropriate disciplinary action. I understand further that making copies of, or using unauthorized software may also subject me to civil and criminal penalties. **My signature below indicates that I have read and understand Policy 02.01.02- Software Copyright Policy and the State of Maryland Software Code of Ethics.**
.....	.....	**02.01.06-Policy to Assure Confidentiality, Integrity and Availability of DHMH Information (IAP)** I acknowledge that I am required to comply with the general applicable sections of this policy as it relates to my current job duties. I further acknowledge that should I breach this policy, I am subject to disciplinary, civil, and criminal consequences. ..... ***02.01.06-IAP–"Specific Personnel" Acknowledgement*** If I am currently designated, or at any time my job duties require me to be designated as a *Custodian, Data Steward, Designated Responsible Party, Database Administrator, and/or Network* (System) Administrator, I acknowledge that I am required to comply with the corresponding responsibilities assigned to ***specific personnel***. Likewise, if I am currently required, or if at any time my duties include the requirement for preparation or monitoring of contracts or memoranda of understanding, I acknowledge that I am required to comply with the ***specific personnel*** provisions of the IAP and guidance.

Employee/User Signature Block

I hereby acknowledge that I have reviewed and understand the above-initialed policies.

Employee/User Signature: _____ DATE: _____

Employee/User Identification (Please Print)

NAME: _____ PIN # or CONTRACT#: _____

AGENCY/COUNTY: _____ ADMINISTRATION/UNIT: _____ LOCATION: _____

Supervisor's Verification

Supervisor Signature: _____ **DATE:** _____

°**Supervisor verifies that the employee/user has acknowledged and initialed the appropriate policies for his/her position.**

DHMH 4518 (REV Nov 2001) This form will be retained in the employee's DHMH personnel file.

Maryland State Department of Health and Mental Hygiene

Section 1 – DHMH Policy on Sexual Harassment

I hereby acknowledge receipt of the DHMH Policy on Sexual Harassment.

****

Section 2 – Executive Order 01.01.01991.16 - Substance Abuse Policy

I hereby acknowledge receipt of the Substance Abuse Policy and the policy overview sheet.

****

Section 3 - DHMH Policy 02.09.01-Policy on Employee's Timely Reporting of Unexpected Absences – AWOL Policy

I hereby acknowledge receipt of the AWOL Policy.

****

Section 4 – General Rules for Drivers of State Vehicles

I hereby acknowledge receipt of the General Rules for Drivers of State Vehicles and I am aware that a violation of these rules would be just cause for disciplinary action under the State Merit System Law.

****

Section 5 – State Ethics Commission

I hereby acknowledge receipt of the Public Ethics Law, and I agree to abide by the provisions summarized within the law. I understand that this is a general summary only and should not be relied upon as a substitute for the Law itself. Additional information on each provision is available on the State Ethics Commission's web site, http://ethics.gov.state.md.us

****

Section 6 – Policy on Equal Employment Opportunity (EEO)

I hereby acknowledge receipt of the Equal Employment Opportunity Policy.

****

I understand that my signature indicates that I have received a copy of each of the policies listed above.

Employee Print Name: _____ **SS#:** _____

Employee Signature: _____ **Date:** _____

For future reference, this page will be maintained in the employee's personnel file.

c: personnel file